BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO SUBJECT OVERVIEW AND SCRUTINY COMMITTEE 2

16 MARCH 2020

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

TRANSFORMATION PROGRAMME ACCELERATING THE PACE OF CHANGE FOR INTEGRATED SERVICES (APCIS)

1. Purpose

1.1 The purpose of this report is to provide an update on progress made on "Accelerating the Pace of Change of Integrated Services (APCIS)" Transformation Programme.

2. Connection to Corporate Improvement Objectives/Other Corporate Priorities

2.1 This report assists in the achievement of the following corporate priorities:-

- **Helping people to be more self-reliant** – taking early steps to reduce or prevent people from becoming vulnerable or dependent on the Council and its services.

- **Smarter use of resources** – ensuring that all its resources (financial, physical, human and technological) are used as effectively and efficiently as possible and support the development of resources throughout the community that can help deliver the Council's priorities.

3. Background

Regional Transformation Programme

3.1 *'A Healthier Wales – Our Plan for Health and Social Care'* [1] set out the Welsh Government's approach to delivering the vision of a whole system approach to health and social care, which is focussed on health and wellbeing, and on preventing illness. The Plan is shaped around the 'Quadruple Aim'– four interlocking themes of:

- Improved population health and wellbeing;
- Better quality and more accessible health and social care services;
- Higher value health and social care; and
- A motivated and sustainable health and social care workforce.

It sets out ten national design principles to drive change and transformation. To deliver the Plan Welsh Government have set up a National Transformation Programme, led by the Director General, Health & Social Services, with local governance through the Regional Partnership Board.

[1] 'A Healthier Wales – Our Plan for Health and Social Care', Welsh Government, 2019, https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

3.2 In January 2019, two transformation proposals separately covering the Bridgend and Cwm Taf (Rhondda Cynon Taf and Merthyr) areas, were made to the Welsh Government having been approved through the appropriate governance structures prior to the creation of the Cwm Taf Morgannwg region. These proposals were subsequently approved and funding of £22.7m was awarded to the Cwm Taf Morgannwg Regional Partnership Board by the Welsh Government in June 2019.

3.3 As a consequence of its origins the Cwm Taf Morgannwg Regional Transformation Programme comprises of two unique strands that reflect the original transformation proposals; Stay Well in your Community (SWYC) relates to the transformation of integrated health & social care services covering the Rhondda Cynon Taf (RCT) and Merthyr localities and Accelerating the Pace of Change for our Integrated Services (APCIS) relates to services delivered within the Bridgend locality (Diagram 1.0).

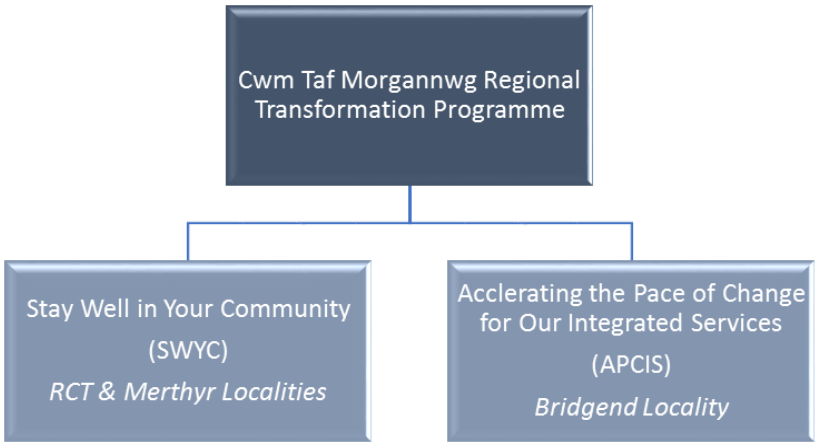


Diagram 1.0 Cwm Taf Morgannwg Regional Transformation Programme

3.4 The Regional Partnership Board (RPB) has established a Programme Management Office (PMO) to coordinate delivery of the Programme across the region. There are eight workstreams; five relating to SWYC and three workstreams or ambitions relating to APCIS. Each workstream/ambition has a dedicated programme lead, programme manager and additional project support. A detailed organisational chart showing the structure of the PMO is attached at **Appendix 1**.

3.5 Three cross-regional programme enabling groups have been established to support the programme covering Finance, Workforce and Digital, Measurement & Evaluation.

3.6 A robust governance framework has been established under the auspices of the Cwm Taf Morgannwg Regional Partnership Board. The local governance structure for ACPCIS sits within this framework and is presented at **Appendix 2.**

3.7 The Institute of Public Care (IPC) has been appointed to carry out an independent evaluation of the impact of the grant funded programme across the region. This evaluation must meet Welsh Government requirements and inform Cwm Taf Morgannwg regional partners about the relative success and potential sustainability of the Programme.

4.0 Current Situation/Proposal

Integrated Health & Social Care Services (Bridgend Locality)

4.1 Bridgend County Borough Council (BCBC) together with its partners in health and the third sector have been committed to developing and delivering integrated services and have over the last 6 years engaged in widening the range of community services within the integrated health and social teams. This has ensured better outcomes for people whilst also meeting the policy aspirations of the Welsh Government for better joined up care.

4.2 The Council's traditional models of service have been through a process of transformation, which are consistent with the aspirations of the Social Services and Wellbeing (Wales) Act 2014 and the Healthier Wales Strategic Plan and are based on the following:

- ***Wellbeing And Prevention*****:** information advice and assistance, including local area coordination and community connectivity
- ***Early Intervention*****:** reablement, progression and recovery approaches in the community
- ***Managed Care and Support*****:** outcome based approaches to complex and long term care, as well as anticipatory coproduce contingency planning with people and their families.

4.3 The focus of our integrated services is on keeping people independent and able and resilient, to enable them to continue to live independently within their communities. However, it is recognised that services alone cannot bring about all the change needed and there is a strong focus upon engaging with the voluntary sector via the Community Voluntary Council (CVC) BAVO as a key partner in service developments, understanding the importance of resilient communities, in supporting people to stay independent.

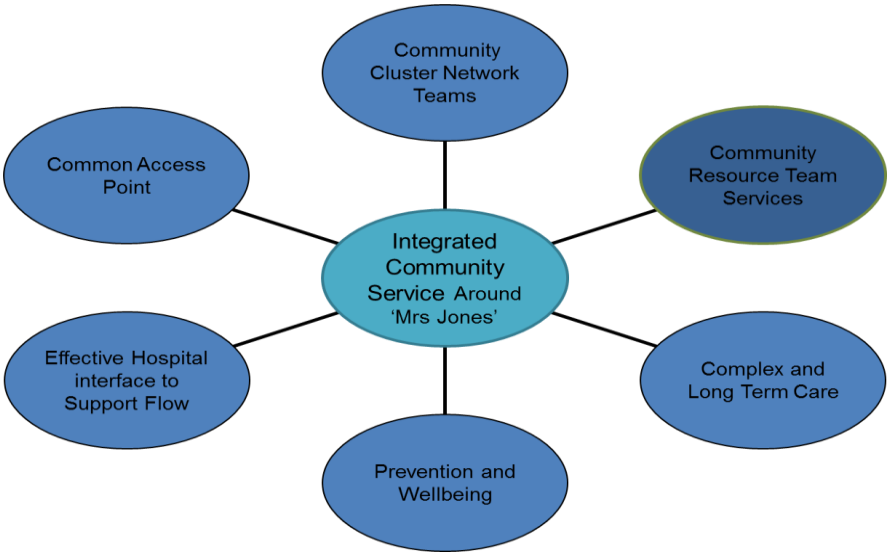
4.4 Success and progress has been predicated on taking a whole system approach to changing the council's services, wrapping services around individuals, particularly for those affected by frailty and disability. In doing so the council has reduced duplication in its system, maximised the use of resources, improved communication and collaboration across social and health and third sector services and delivered tangible improved outcomes for people using community services in Bridgend County Borough.

4.5 The integrated services are now well established and include the following:

- Common Access Point (CAP) for all adult services and community services for frail, older and disabled people
- Community Resource Team Services, including Acute Clinical Team, Reablement, Community Occupational Therapy, Telecare and Mobile Response
- Better@Home Bridging Service
- Integrated Community Cluster Network Teams comprising Social Work and District Nursing.
- Integrated community equipment services and the extensive rollout of Telecare and 24 hour mobile regulated response services

All of the above is underpinned with collaboration with the third sector and universal services.

Diagram 2.0 Integrated Community Services in Bridgend



4.6 Progress to date has been delivered mainly through the reconfiguration of existing resources and the support of the Integrated Care Fund. The Transformation Fund offers an opportunity to consolidate proven success to date and to accelerate our integrated working at pace and scale, working towards a sustainable and optimal model of health and social care.

Transformation Fund - Accelerating the Pace of Change for Our Integrated Services (APCIS)

4.7 The overarching aim of the APCIS Transformation Programme is to *deliver fully accessible coordinated health and social care services seamlessly wrapped around the needs and preferences of individuals.* The programme is broken down into three transformational ambitions:

Ambition 1: Seven Day Access to Community Health and Social Care Services – *"Every Day Is Tuesday"*, delivering extended alternative service options to hospital and long term care.

Ambition 2: A Primary and Community Care Multidisciplinary Team approach, delivering a one team approach around people, coordinating Primary Care and Community Services Cluster responses.

Ambition 3: Developing and Delivering Resilient Coordinated Communities; with key organisations, their partners and the communities that they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

Diagram 3.0 Transformation Principles

4.8 The connected transformational ambitions will serve to achieve the following overarching outcomes:

- Individuals will be able to navigate the range of short and long term support services or mechanisms that meet their individual needs, empowering them to remain independent for as long as possible in their home;
- More efficient use of available resources;
- Prevention of ill-health, enabling people to keep themselves well and independent for as long as possible;
- More resilient co-ordinated communities.

The outputs from this component of the programme will be:

- Reducing the need for hospital stays;
- Reducing the length of hospital stays when they occur;
- Development of the existing Common Access point to a seven day service accessible from 8 am to 8 pm;
- Expansion of the existing Better@home service to become more connected to clinicians and to the 'front door' of hospital admissions;
- Expansion of the current Mobile Response Team (MRT) to one each for the north and south of the locality, with an expanded scope of delivery to support fallers in the home;
- Additional support from the MRT to support the District Nursing team.
- A multidisciplinary community cluster model;
- Increased capacity for integrated community clusters network teams;
- An integrated care homes support service
- Development of a more co-ordinated approach to building resilient communities;
- A Prevention and Wellbeing plan;
- Remodelling of local community co-ordination.

Ambition 1: Seven Day Access to Community Health and Social Care Services – *"Every Day Is Tuesday"* delivering extended alternative service options to hospital and long term care

4.9 The current configuration of the council's Community Health and Social Care Services are based on traditional models of service access and delivery, from Monday to Friday mainly between 9 am and 5 pm. This creates pressure within the system particularly at the beginning and the end of the working week; for example people wait over the weekend for senior reviews on Mondays in hospitals; people are referred to health, social and integrated services on Mondays, where there has been a personal or family crisis over the weekend, with an expectation of support and resolution of their issues immediately.

4.10 The real activity of the week commences following a rapid and intense period of assessment and planning on Tuesdays; and by Fridays community services are fully committed and usually at capacity; this inevitably means that some people have to either wait until the following week, or will remain in hospital unnecessarily, or will need temporary avoidable care arrangements to be put in place until their issues can be resolved the following week.

4.11 The transformation programme will support the development of fully operational accessible services over seven days, over an extended day. This will ensure a coordinated integrated approach to service operation where '*Every Day Is Tuesday'*; where the flow of people in and out of services is continuous and accessible.

4.12 **To realise this ambition, the transformation programme will deliver the following:**

- A Common Access Point open seven days a week 8 AM to 8 PM for access to coordinated community health and social care and third sector support;
- Non-selective reablement/enabling services accessible over seven days;
- Expansion of the better at home bridging service, over seven days;
- Expansion of the current Mobile Response Team (MRT) to provide two teams to cover the north and south of the locality, with an expanded scope of delivery to support fallers at home.

Timeline for delivery

The anticipated "Go Live" dates are summarised in Table 1.0 below. The Red, Amber, Green (RAG) is the status of progress/expected delivery. Red indicates that the project will not be delivered, amber indicates that the project will delivered but timelines are likely to be delayed and green indicates that the project will be delivered within the agreed timelines.

	Go Live Date		RAG**
Common Access Point	1st Phase – extended day	2nd Phase- Extended day and 7 day services	
	End of March 2020	End of June 2020*	
Reablement/Enabling Services	End of March 2020	End of June 2020*	
Better@Home expansion	End of June 2020		
Mobile Response Team expansion	End of Feb 2020		

*Dependent on evaluation of Phase 1

** Dependent on the recruitment of appropriate numbers of staff to safely deliver service

Progress to date:

4.13 Ambition 1 is currently within the “active preparation” stage of delivery with the focus on recruiting staff and the development of new operating models.

Progress has been highly dependent on the recruitment of staff to support the expansion of the existing services.

Significant progress has been made in recruiting to the Common Access Point and the Service is optimistic that the team can work towards extended hours by the end of March 2020. To date the Service have recruited successfully to all the Mobile Response posts however, a number of staff have moved internally from core services which presents a risk to the delivery of these services if staff are mobilised.

A targeted recruitment campaign has been initiated to support recruitment for Support Worker posts within the Better@Home and Reablement services including the use of Social Media, radio advertising and a series of recruitment fairs.

Work is underway to develop new pathways and operating models across the three ambitions and a series of workshops have been undertaken to develop this work.

Meetings have been arranged to engage with the commissioned IPC evaluation team.

4.14 **Ambition 2:** ***Delivering a One Team Approach around People*****.** A Primary and Community Care Multidisciplinary Team Approach, delivering a one team approach around people, coordinating Primary Care and Community Services Cluster responses.

The Service want to develop the ability to deliver a multidisciplinary team around people in the Community Cluster Networks, comprising primary care professionals, and an expanded community cluster network team to support timely and responsive assessments around individuals receiving care and support at home. This approach will also facilitate anticipatory and contingency planning with people and their families, their care providers and the community and primary care teams, at home or in care home settings.

To realise this ambition the Service want to deliver the following:

- Integrated Community Network Teams delivering a primary care multidisciplinary workforce linked strongly to the Cluster Networks focusing on anticipatory/contingency planning to prevent unnecessary admission to hospital or long-term care;
- A Multidisciplinary team approach, to wrap assessment and services around people;
- An Integrated care home support service.

Timeline for delivery

The anticipated "Go Live" dates are summarised in Table 2.0 below

Ambition 2	Go Live Date		RAG**
Single Point of Access	Extended days	April 2020	
Fully Integrated Network teams	All staff recruited	May 2020	
Multi -Disciplinary Model (MDT) implemented	June 2020		

Progress to date:

4.15 The Single Point of Access has been operating on minimum staffing as a pilot phase. All new staff have been recruited with the aim to be in post and trained in preparation for extended day service delivery in April 2020.

The recruitment process for the integrated networks is well underway with almost all staff appointed. These staff will build on the already existing network teams to increase capacity for anticipatory care planning and the MDT operating model.

Accommodation planning has been initiated to accommodate all of the new staff. ICT infrastructure changes are in process to support the networks.

There have been workshops carried out with various disciplines to map new referral pathways and the model for service delivery. This element requires further work between short and longer term services.

GP engagement has been implemented with the aim to involve them in shaping the MDT model. Engagement sessions are being planned to inform the model.

Meetings have been arranged to engage with the commissioned IPC evaluation team.

4.16 **Ambition 3: Developing and Delivering Resilient Coordinated Communities**; with key organisations and the communities that they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

In partnership with the CVC, a third sector telephone brokerage service will operate alongside core services, providing support as well as information to individuals. The brokerage would provide a single information access point, on what is available in local communities in relation to community activities, groups, services and facilities, enabling appropriate signposting to third sector and community based support, that could improve the individual's overall health and wellbeing and empowering them to remain independent for as long as possible in their home and community.

Good information is essential to making 'every contact count', and in promoting wellbeing and resilience; good connections between local services and accessibility of support are essential. Within such an approach, that includes areas such as information, advice and assistance (IAA), social prescribing, compassionate communities and local community coordination, the importance of the third sector and local community based resources is recognised. It will enable the Authority, Local Health Board, The Clusters and CVC to make best use of resources and to apply evidence and results based approaches to service planning and delivery.

Timeline for delivery

The identified workforce within the transformation plan has been recruited and the project has been mobilised (Gone LIVE).

4.17 **Progress to date:**

A performance framework, based on the "balanced scorecard model" has been created identifying the evaluation commitments contained within the related funding application. This includes performance indicators that consider financial, process, customer and learning/growth aspects of the programme.

BCBC and BAVO are establishing a series of project team meetings that will maintain momentum and support reporting procedures.

There will be investment into the third sector to further develop skills, knowledge and confidence and to future proof the third sector to contribute to prevention and wellbeing.

Both BCBC and BAVO are active within the Cwm Taf Morgannwg steering group for social prescribing to develop common standards and approaches to community referral work. A mapping exercise has taken place to support the development of a regional picture.

Meetings have been arranged to engage with the commissioned IPC evaluation team.

5. Effect upon Policy Framework & Procedure Rules

5.1 There is no effect upon the Policy Framework and Procedure Rules.

6. Equality Impact Assessment

6.1 This programme is part of a regional programme approach as described in the report. The Equality Impact Assessment tool is being completed by the regional programme structure. A full Equality Impact Assessment will be completed throughout the programme by the regional team when required.

7. Well-being of Future Generations (Wales) Act 2015 Assessment

7.1 The implementation of the duties and responsibilities under the Social Services and Wellbeing (Wales) Act 2014 (SSWBA) supports the promotion of two of the seven goals of the Well-Being of Future Generations (Wales) Act 2015 within the County Borough of Bridgend. By promoting an environment that maximises people's physical and mental well-being and by supporting children, young people, adults and their carers and families to fulfil their potential no matter what their circumstances, the wellbeing goals of a Healthier and more equal Bridgend and Wales are supported.

7.2 The Well-being of Future Generations (Wales) Act 2015 provides the basis for driving a different kind of public service in Wales, with five ways of working to guide how the Authority should work to deliver wellbeing outcomes for people. The following is a summary to show how the five ways of working to achieve the well-being goals have been considered in this report:

- **Long Term** – Social Services is demand led and the SSWBA focusses on sustainable prevention and wellbeing outcomes for the future. There is a requirement to meet the needs of people in the longer term and, because of rising demographics and increasing complexity, the remodelling and transformation of services continues to be a priority. For people living with chronic ill-health and disability the Service are developing the ability to deliver a multidisciplinary team around people in the Community Cluster Networks. The multidisciplinary team will comprise of primary care professionals, and an expanded community cluster network team to include additional therapies to support timely and responsive assessments around individuals receiving care and support at home. The increased capacity within the integrated network teams will support people to stay in their homes independently for longer. Working within the MDT model enables closer working with GPs for a more effective and quicker response to those in long term care services to meet the needs of our service users/patients and anticipate the resources required to better manage demand. There would also be an opportunity to reduce inappropriate hospital admissions through anticipatory care planning.
- **Prevention** – A Common Access Point (CAP) will be open seven days a week 8 AM to 8 PM for access to coordinated community health and social care and third sector support offering Information, Advice and Assistance which will enable people to remain independent for as long as possible. Short term services based within the Community Resources Team (CRT) will focus on people who have not been in services before, as well as expediting discharge from hospital. This will enable the core services to deliver prudent care coordination to support individuals, their carers' and families at home, with appropriate interventions and responses as their illness and/or disability progresses to prevent inappropriate admissions to hospital or long-term care.
- **Prevention** – Working within the MDT model enables closer working with GPs for a more effective and quicker response to those in long term care services to meet the needs of our service users/patients and anticipate the resources required to better manage demand. There would also be an opportunity to reduce inappropriate hospital admissions through anticipatory care planning.
- **Prevention** – In partnership with the CVC third sector a telephone brokerage service will operate alongside CAP providing support as well as information to individuals. The brokerage would provide a single information access point regarding availability and access to local communities in relation to community activities, groups, services and facilities. The appropriate signposting to third sector and community based support could improve the individual's overall health and wellbeing and empower them to remain independent for as long as possible in their home and community.
- **Integration** – The CRT within short term services will provide a coordinated integrated approach to service operation flow of people in and out of the service for continuity and accessibility.
- **Integration** – The colocation of a multi-disciplined integrated team in the networks will enable a more joined up approach for information sharing, planning and ability to meet the needs of our service users/patients.
- **Integration** – Working with the third sector and the community will support integration across the ambitions offering social prescribing opportunities and integrated approaches to well-being.
- **Collaboration** – the strategic planning and local delivery of integrated support and services have been developed and agreed at a regional basis in order to provide the best possible intervention to people. Key organisations and the communities that they serve will develop benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

- **Involvement** – the main key stakeholders are the people who use the health and social care services. Health and social care providers who will be developing and shaping the operating models are also key to service change, development and delivery. There is considerable engagement including surveys, stakeholder meetings, feedback forms, digital stories and the complaints process. The provision of accessible information, advice and assistance helps to ensure that the voices and needs of adults, children and young people are heard.

It is important to recognise that the 3 ambitions within Transformation will be working collaboratively across the programme to support and enable the best outcomes for the individual.

8. Financial Implications

8.1 On 10 June 2019 Welsh Government announced Transformation Fund investment of £22.7m in Cwm Taf Morgannwg Regional Partnership available until the end of March 2021.

To achieve ongoing financial sustainability the regional partnership agreed to prioritise the transformational investment to ensure that recurrent investment required to deliver the programme post March 2021 could be met by the region.

Following completion of the prioritisation approach, the RPB agreed that each of the transformation fund proposals would reduce their investment - the Bridgend element is detailed below as per Table 3 :

TABLE 3.0	2019-20 £k		2020-21 £k		Total £k	
	Original	Revised	Original	Revised	Original	Revised
APCIS	3,366	2,799	3,307	3,239	6,673	6,038
Total					**6,673**	**6,038**

8.2 Welsh Government have recently agreed to slip £654k (£393k – Ambition 1 and £261k – Ambition 2) of funding from 2019-20 into 2020-21. The revised budget for 2019-20 now stands at £2.15m (£2.8m - £654k) and £3.9M (£3.24m + £654k) for 2020-21.

8.3 The projected spend for 2019-20 currently stands at £1.42m against the 2019-20 investment of £2.15m, which leaves a projected underspend of £730k.

8.4 The breakdown of the expected recurrent investment required, from **2021-22 (Year 3) and onwards**, once the Transformation Funding has ended, by workstream/ambition for APCIS is set out in Table 4 below:

TABLE 4.0 APCIS	**Revised 2021-22 Recurrent FYE Funding Requirement** (Inc. inflation) **£k**
Ambition 1: Every Day is Tuesday	1,579
Ambition 2: One Team Around the Person	1,041
Ambition 3: Resilient Co-ordinated Communities	0
TOTAL	**2,620**

This investment required in Year 3 is planned to be met from a combination of recurrent Welsh Government ring-fenced investment and costs anticipated to be released from the wider health and social care system as a consequence of the transformation Programme. A detailed breakdown of the Sustainability Plan including details of the ring fenced investment is attached at **Appendix 3 (Tables 5 and 6).**

9. Recommendation

9.1 It is recommended that Subject Overview and Scrutiny Committee 2 consider the progress made in relation to the Regional Transformation Programme – Accelerating the Pace of Change for Integrated Services; and to receive a further report in 6 months' time which will show the impact and outcomes on individuals.

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February 2020

10. Contact Officers:

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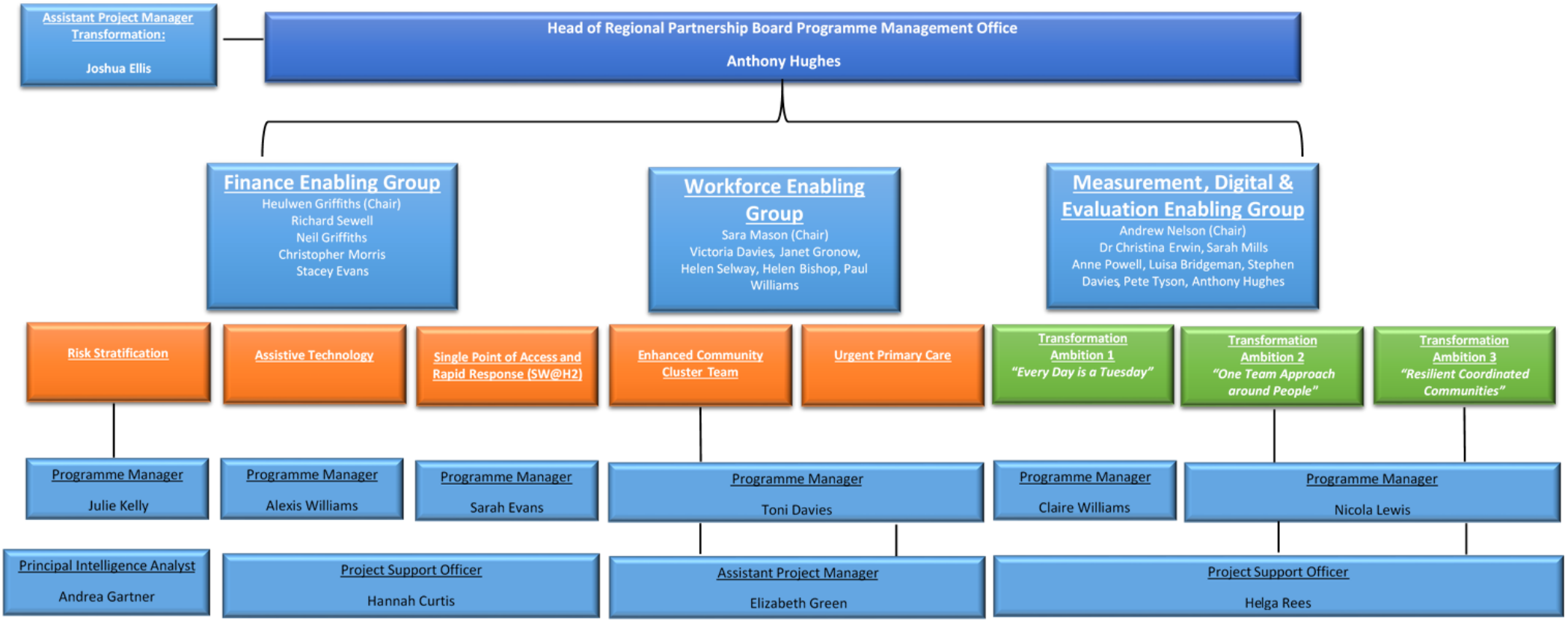
11. Background documents:

None

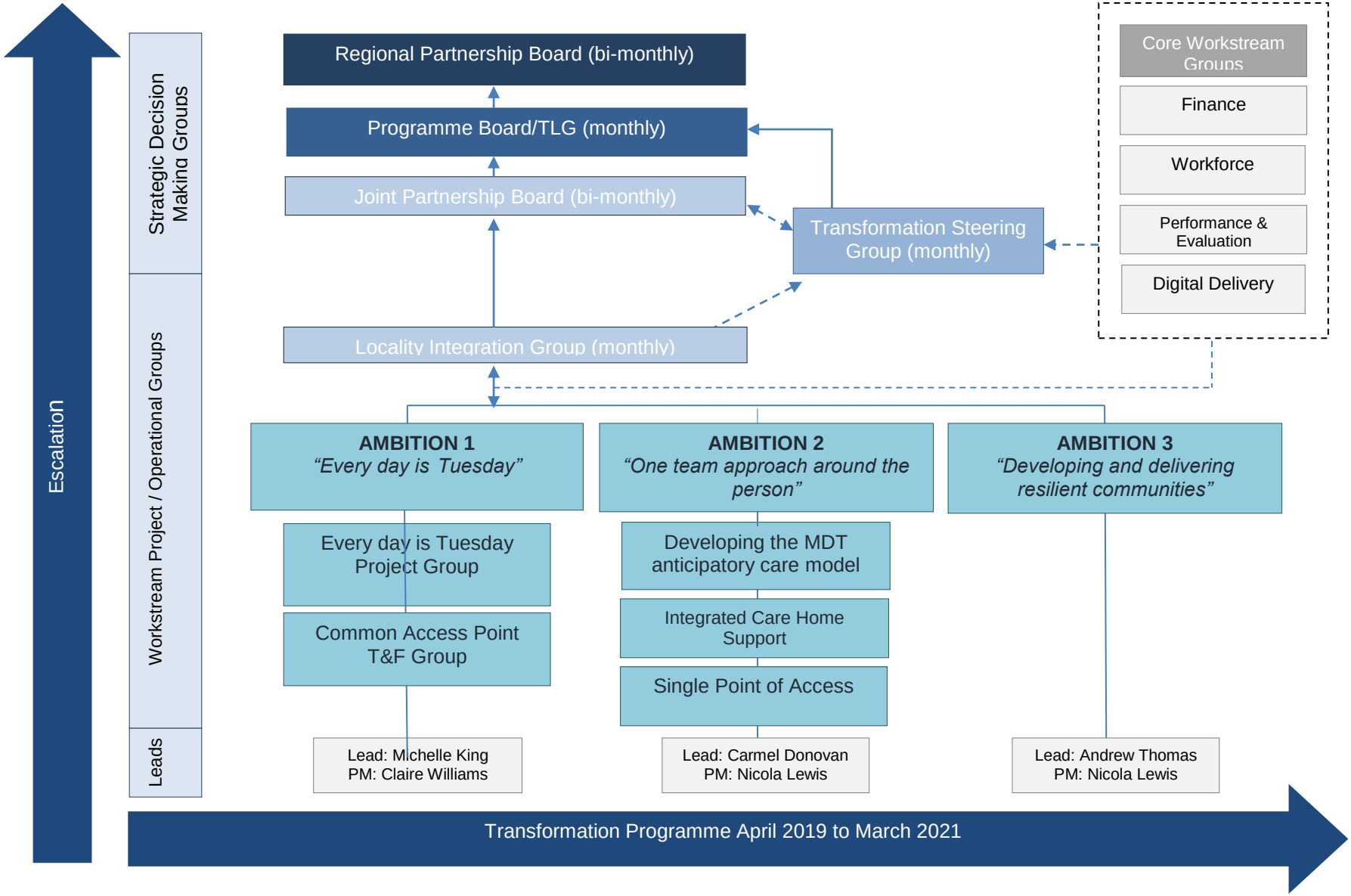
Appendix 1

Regional Partnership Board Programme Management Office



Appendix 2

Governance Structure: Accelerating the Pace of Change for our Integrated Services (APCIS)



Appendix 3

Table 5.0 Financial Sustainability Plan

Accelerating the Pace of Change of Integrated Services (APCIS)	2019/20 Recurring £k	2019/20 Non-recurring £k	2019/20 Slippage into 2020/21 £k	2019/20 Total £k	2020/21 Recurring £k	2020/21 Non-recurring £k	2020/21 Total £k	2020/21 Slippage from 2019/20 £k	2020/21 Revised Total £k	2021/22 onwards Recurring £k	2021/22 onwards Non-recurring £k	2021/22 onwards Total £k	
Transformation Funding from WG	0	-2,799	654	-2,145	0	-2,439	-2,439	-654	-3,093	0	0	0	Note 2
Use of recurrent funding streams to part fund transformation investment													
Primary care	0			0	-174		-174		-174	-259		-259	
Digital	0			0	-35		-35		-35	-21		-21	
RPB	0			0	-227		-227		-227	-520		-520	
Prevention	0			0	-182		-182		-182	-112		-112	
Mental health	0			0	-181		-181		-181	-261		-261	
Total	**0**	**0**		**0**	**-799**	**0**	**-799**		**-799**	**-1,173**	**0**	**-1,173**	Note 3
Release of costs from existing models of care as a consequence of transformation	0	0		0	0	0	0		0	-1,447	0	-1,447	Note 4
Total Transformation income/cost release	**0**	**-2,799**	**654**	**-2,145**	**-799**	**-2,439**	**-3,238**	**-654**	**-3,892**	**-2,620**	**0**	**-2,620**	
Net Effect on Plan	**1,498**	**-1,498**		**654**	**1,815**	**-1,815**	**0**			**0**	**0**	**0**	

Note 1
Expenditure budget as per Annual and Monthly tabs
Includes reduced expenditure from prioritisation exercise

Note 2
Revised funding agreed after prioritisation exercise

Note 3
Income streams as per WG approved bid May 2019

Note 4
Cost release exercise detailed in 'Cost Release' tab

Appendix 3

Table 6.0.Risk adjustment of cost release from wider system to invest in transformation model

Accelerating the Pace of Change of Integrated Services – Risk Adjusted Cost Release Plan	Annualised Cost Release from 2021/22 £k	Rationale
Reduced bed days resulting from reduced acute hospital admissions and shorter lengths of stays	1,375	8,670 bed days avoided @ £158 per bed day based on bed day reduction (including nursing, non-pay, and hotel services costs)
Reduction in A&E attendances	117	Assumed 4.2% attendances avoided based on modelling of the impact anticipatory care and assumed further 3% from Better@Home. Assumed marginal cost release @ £25 per attendance
Reduction in Ambulance Conveyances	101	Assumed 7.2% reduction in ambulance conveyances @ £200 per conveyance @ 50% marginal cost reduction
Reduction in Urgent Primary Care Out of Hours Demand	63	Assumed 7.2% reduction in relevant PCOOH contacts of 45990 @ £88 unit cost @ 50% marginal rate
Reduction in existing social care costs as a consequence of the new investment in social care	339	This is based on 20% of the social care investment.
Total impact on Health and Social Care costs before Risk Adjustment	1,995	
Total impact on Health and Social Care costs after 65% Risk Adjustment	**1,297**	
Additional cost release from existing community mental health resources	150	0
Overall total cost release from reinvestment in transformation model	**1,447**	**0**